PATIENT QUESTIONNAIRE

NAME

CONFIDENTIAL

BIRTHDATE

TODAY'S DATE

			DENTA	L HI	STORY		
1	Reason for visit:						
	When was your last dental visit?					. (10	
	1985 3 Mg	19		J.		ę.	ereperi à
	How often do you brush your teeth?		Medium		Hard	475	especial C
4.	What texture brush do you use? 🗖 Soft					YES	NO
Б	Do your gums bleed while brushing?	YES		13	Have you had any head, neck, or	ILU	1000
	Do your gums bleed when flossing?			10.	jaw injuries?		
				14	Do you have frequent headaches?		
	Do you feel pain to any of your teeth when brushing or flossing them?	П			Do you clench or grind your teeth		
	Are your teeth sensitive to hot, cold,			10.	while awake or asleep?		
	sweet or sour foods/liquids?			16.	Do you bite your lips or cheeks frequently?		
	Have you noticed any loosening of				Have you ever had:	or together	
	your teeth?			171	a. Orthodontic treatment (braces)?		
	Does food tend to become caught				b. Oral surgery?		
	between your teeth?				c. Gum treatment?		
	Do you have any sores or lumps in or				d. Your teeth ground or the bite adjusted?		0
	near your mouth?				e. Worn a bite plane or other appliance?		8 🔲 63 - 8
2.	Have you ever experienced any of the			18.	Are you satisfied with the appearance		OTHER Y
	following problems in your jaw?				of your teeth?		
	a. Clicking?			19.	Have you ever had an upsetting		
	b. Pain (joint, ear, side of face)?				experience in the dental office?		
	c. Difficulty in opening or closing?			20.	Is there anything about having dental		_ //
	a Difficulty in charring?				troatment that bothers you?		
	d. Difficulty in chewing?				treatment that bothers you?		
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MEDICAL I	HISTO	RY C	ONTINUED	
Are you allergic to or have you had reactions to: 1. Local anesthetics like novocaine? 2. Penicillin or other antibiotics? 3. Sulfa drugs? 4. Barbiturates, sedatives or sleeping pills? 5. Aspirin? 6. Iodine? 7. Other? Do you have or have you ever had the following: 1. Rheumatic heart disease or rheumatic fever? 2. Scarlet fever? 3. Heart defect or heart murmur? 4. Heart trouble, heart attack, or angina? A. Do you have pain in your chest upon exertion? B. Are you ever short of breath after mild exercise? C. Do your ankles swell? D. Do you get short of breath when you lie down? E. Do you require extra pillows when you sleep? 5. Pacemaker? 6. Heart surgery? 7. High blood pressure? 8. Low blood pressure? 9. Hepatitis, jaundice or liver disease? I certify that the information listed is complete and accumus. DATE	YES	NO 000000 00000000000	10. Stroke? 11. Sinus trouble? 12. Lung or breathing problems? 13. Asthma or hay fever? 14. Hives or skin rash? 15. Fainting spells or seizures? 16. Diabetes? 17. AIDS or HIV infection? 18. Thyroid problems? 19. Allergies? 20. Arthritis or rheumatism? 21. Joint replacement or implant? 22. Stomach ulcer? 23. Kidney trouble? 24. Tuberculosis? 25. Persistent cough? 26. Cough that produces blood? 27. Cancer? 28. Sexually transmitted disease?	NO O O O O O O O O O O O O O O O O O O
FOR COMPLETION BY THE DENTIST: SUMMARY OF DENTAL HISTORY SUMMARY OF MEDICAL HISTORY MEDICAL HISTORY UPDATE: COMMENTS			INITIALS: PATIENT DENTIST	HYGIENIST
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